

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01905

Reg. Dist. No.

1902

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Garrett</u> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland, Maryland</u>		c. LENGTH OF STAY IN 1b <u>15 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Richard</u> <u>Stabler</u> <u>Browning</u>		<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>15</u> Year <u>1959</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>April 17th., 1875</u>
<b>9. AGE</b> (In years last birthday) <u>83</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Game warden (Retired)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Richard Thomas Browning</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Harriett Twigg</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Mr. Getty Browning, Raleigh, N. C.</u>		<b>Address</b> <u>  </u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRATHORACIC HEMORRHAGE</u> <u>825x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CRUSHED ANTERIOR CHEST WALL FOLLOWING AUTO ACCIDENT</u> (c), stating the underlying cause last. DUE TO <u>16 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>In auto accident about 6:30 P. M. 2-14-59 near Deer Park, Md.</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>6:30</u> <u>2-14-59</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Md. Rt. 135</u>	<b>20f. (City or town)</b> (County) (State) <u>Nr. Deer Park, Md.</u>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>James H. Feaster, Jr.</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <u>James H. Feaster, Jr., M. D.</u>		<b>DATE SIGNED</b> <u>2-15-59</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>2/18/1959</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Catholic Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Oakland, Maryland.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>A. C. Leighton</u>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>FEB 19 '59</u>	
<b>ADDRESS</b> <u>Oakland, Md.</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kious</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 and 2 with the registrar prior to burial, cremation or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1903

## CERTIFICATE OF DEATH

01906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>JENNINGS MD</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Ellen</b> Last <b>Butler</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 8, 1896</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>GARRETT Co, MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JESSE WILT</b>				14. MOTHER'S MAIDEN NAME <b>RACHAEL PLATTIER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Name <b>Mrs Lloyd Bittinger</b> Address <b>Jennings Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Diabetes Mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneous</b> <b>15 years</b> <b>15 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Has had both lower limbs amputated (1957 + 1958)</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>October</b> , 19 <b>57</b> , to <b>January</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>December 15, 1958</b> , and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Herbert H. Leighton</b>				DATE SIGNED <b>77 Oak St., Oakland, Md. 1 Feb 59</b>			
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M.D.</b>				ADDRESS <b>77 Oak Street, Oakland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WILT</b>		22d. LOCATION (City, town, or county) (State) <b>RURAL LONACOWING, GARRETT Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J Newman, Grantsville, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CERTIFICATE OF DEATH

01907

Reg. Dist. No.

1904

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b>		c. LENGTH OF STAY IN 1b <b>33 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Center St.</b>		d. STREET ADDRESS <b>Center St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mae</b> Middle <b>Florence</b> Last <b>Clark</b>		4. DATE OF DEATH <b>February 7, 1959</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abe Dawson</b>		14. MOTHER'S MAIDEN NAME <b>Jane Helmick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>John R. Clark</b>		Address <b>Kitzmiller, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>2 years</b> <b>8 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/15/57</b> to <b>2/7/59</b> , that I last saw the deceased alive on <b>1/29/59</b> , and that death occurred at <b>3:35A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. E. Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. E. Mance, M. D.</b>		DATE SIGNED <b>9 Feb 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Elk Garden, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	24a. REC'D BY REGISTRAR <b>FEB 10 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1905

## CERTIFICATE OF DEATH

01908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b> c. LENGTH OF STAY IN TB <b>4 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Cuppett Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Edna</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1878</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Louis Davis</b>	
14. MOTHER'S MAIDEN NAME <b>Louisa Gleichman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Cuppett Nursing Home</b> Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>4:50 P</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 1957</b> to <b>FEB 1959</b> , that I last saw the deceased alive on <b>Feb 11, 1959</b> , and that death occurred at <b>4:50 P</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. I. Baumgartner</b>		DATE SIGNED <b>1/14/59</b>	
PHYSICIAN'S NAME (Type) <b>E. I. Baumgartner, M. D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/16/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Methodist Cem.,</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 19 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		West Virginia		b. COUNTY		Tucker	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Oakland		c. LENGTH OF STAY IN 1b		7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Davis		85x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Garrett County Memorial Hospital		d. STREET ADDRESS		Box 216		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day	
Thomas		Hammond		February		6		19		59			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6-24-78		80		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		Retired Coal Miner		W. Va.		America	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Francis Marion Hammond		Louisa Cunningham							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Box 216		Address					
				(Wife) Stella McCray Hammond, Davis, W.V.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		331X		DUE TO		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH		7 Days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		Arteriosclerosis with hypertension		10 years					
		(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
Hour a. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
21. I certify that I attended the deceased from 3/13/1956 to 2/6/1959, that I last saw the deceased alive on 2/5/1959, and that death occurred on 2/6/1959 at 11:15 AM, from the causes and on the date stated above.													
ACTUAL SIGNATURE		Andrew E. Mance		M.D.		Oakland Md		DATE SIGNED		6 Feb 59			
PHYSICIAN'S NAME (Type)		Andrew E. Mance, M. D.,				Oakland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)					
Burial		Feb. 9, 1959		Davis Cemetery		Davis		W. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE		Wayne C. Hizzle		ADDRESS		Davis, W. Va.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
								DATE		FEB 11 '59			

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

30

MASSACHUSETTS  
BUREAU OF VITAL RECORDS  
DEPARTMENT OF HEALTH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Place of Death		Cause of Death		Manner of Death	
Occupation		Education		Religion		Marital Status	
Date of Birth		Date of Marriage		Date of Death		Date of Burial	
Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Witness	
Date of Registration		Date of Death		Date of Burial		Date of Interment	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01910

1907

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Preston</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Caklard</b>		c. LENGTH OF STAY IN 1b <b>6 hrs. 48 min.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Leola Mae Kisner</b>		4. DATE OF DEATH Month Day Year <b>February 2 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1909</b>
9. AGE (In years last birthday) <b>49 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Brennenman</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Bittinger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Agnes Brennenman</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4 + x DUE TO <b>Malignant Essential Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction with chronic glomerulonephritis (left)</b> <b>Rheumatic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>7 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1934</b> , 19 <b>Feb 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 2</b> , 19 <b>59</b> , and that death occurred at <b>5:05 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles E. Smith</b> M.D.		ADDRESS (Street, city or town, state) <b>Terra Alta, W. Va.</b> DATE SIGNED <b>Feb 2, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Charles E. Smith, M.D.</b>		<b>Terra Alta, W. Va.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Removal &amp; Burial</b>		<b>2/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Oak Grove Cemetery</b>		<b>Route # 2, Terra Alta, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William</b> ADDRESS <b>Terra Alta, W. Va.</b>		24a. REC'D BY REGISTRAR	
<b>MD. F.D. License No. A 6834</b>		24b. REGISTRAR'S SIGNATURE	
DATE <b>FEB 4 '59</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1908

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>Edward</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 5, 1910</b>
9. AGE (in years last birthday) <b>49 yrs</b>		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>student</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Playford Lee</b>		14. MOTHER'S MAIDEN NAME <b>Marie F. Broadwater</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>19-11-1111</b>	
17. INFORMANT <b>Playford Lee</b>		18. ADDRESS <b>Garrett County, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>196.7</b> DUE TO <b>Ascaromatosis - pulmonary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primary left femur</b> (c) <b>2 year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>no</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>no</b>		20f. (City or town) <b>no</b> (County) <b>no</b> (State) <b>no</b>	
21. I certify that I attended the deceased from <b>February 23, 1951</b> to <b>February 7, 1959</b> , that I last saw the deceased alive on <b>February 7, 1959</b> , and that death occurred at <b>3:35 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		DATE SIGNED <b>7 Feb 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Andrew E. Mance, M.D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ACCIDENT</b>		22d. LOCATION (City, town, or county) <b>ACCIDENT GARRETT Co. MD.</b> (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don F. Newman, Gaithersville Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 13 1959</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>			

VS A15 (4)  
M 10/57





1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01912

## 1909 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>MD</u> COUNTY <u>Garrett</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Rural Friendsville</u>		LENGTH OF STAY (In this place) <u>Life</u>		X TOWN <u>Rural Friendsville</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				/ STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIAM JACKSON LYTLE</u>				<u>Feb. 27 19 59</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>June 2m 1882</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer retired</u>		<u>own Farm</u>		<u>Selbysport, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>David Lytle</u>				<u>Latilda Summy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>220-05-75501</u>		<u>Mrs. Sarah Bowser, Friendsville Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4. IMMEDIATE CAUSE (A)				<u>Cardiovascular Failure</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO			
				<u>Aging</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>NONE</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>Nov 59</u> , 19 <u>59</u> , to <u>Feb 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 27</u> , 19 <u>59</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>John E. Kneass</u>		<u>Friendsville Md</u>		<u>2/28/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/1/59</u>		<u>FRIENDSVILLE</u>		<u>FRIENDSVILLE GARRETT, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>MAR 3 '59</u>		<u>John E. Kneass</u>		<u>Don Newman, Friendsville, Md.</u>			
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the Registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01913

1910

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>	c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRELLIN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EMARAL</b> Last <b>MERSING</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/16/1883</b>
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>soft coal mines</b>	11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>THOMAS MERSING</b>		14. MOTHER'S MAIDEN NAME <b>ROSALIE NUSBOUMER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>213-10-3709</b>	
17. INFORMANT <b>(DAUGHTER) ANNA GRAHAM</b>		Address <b>CRELLIN, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>COLONIAL OCCLUSION</b> DUE TO <b>WITH HEART BLOCK</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1957</b> to <b>Feb. 6, 1959</b> , that I last saw the deceased alive on <b>Feb 6, 1959</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. I. Baumgartner</b> M.D.		ADDRESS (Street, city or town, state) <b>2500 57 Oakland Md</b> DATE SIGNED <b>2/6/59</b>	
PHYSICIAN'S NAME (Type) <b>E. I. BAUMGARTNER</b>		<b>ALDER STREET - OAKLAND, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/9/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ashby Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>near Crellin, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Keighton</b>		ADDRESS <b>Oakland, Md.</b>	24. REG'D BY REGISTRAR <b>FEB 10 59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1911

## CERTIFICATE OF DEATH

Reg. Dist. No.

01914

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>63 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jackson</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Vans Nursing Home</u>		d. STREET ADDRESS <u>Second street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Estelle</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/26/1877</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Frostburg Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Miller</u>	
14. MOTHER'S MAIDEN NAME <u>Luzan Offutt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Thorton Deffinbaugh</u> Address <u>Oakland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>February</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 13</u> , 19 <u>59</u> , and that death occurred at <u>9:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>25 Alder St. Oakland, Md.</u> DATE SIGNED <u>2/14/59</u> ACTUAL SIGNATURE <u>E. I. Baumgartner</u> M.D. PHYSICIAN'S NAME (Type) <u>E. I. Baumgartner, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2/15/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oakland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn H. Winkler</u>		ADDRESS <u>Oakland, Md.</u>	24a. REC'D BY REGISTRAR <u>553 19 59</u>
24b. REGISTRAR'S SIGNATURE <u>  </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

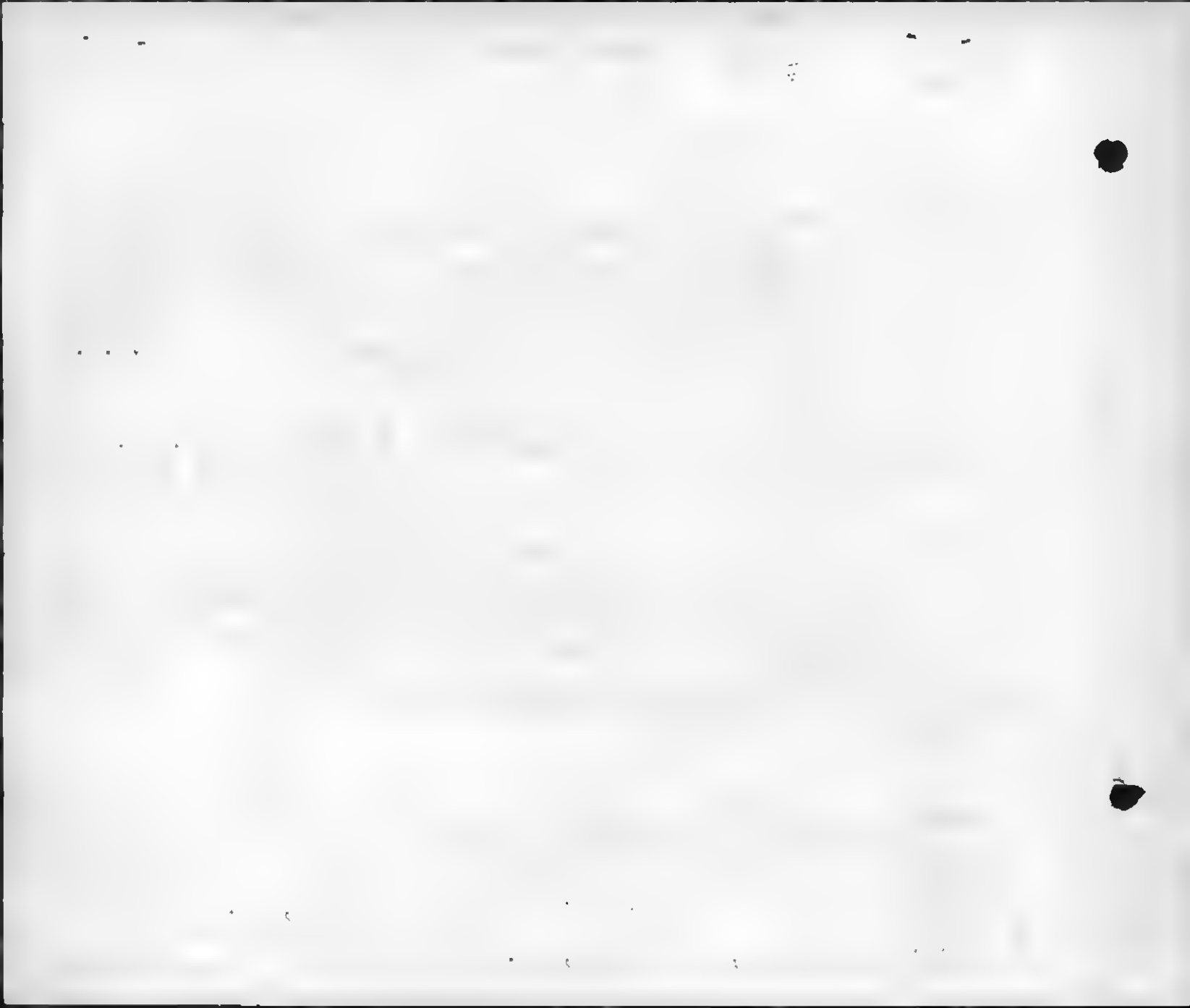
1912

CERTIFICATE OF DEATH

01915

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ONE TOWN</u>		c. LENGTH OF STAY IN 1b <u>1 wk.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nikep</u>		d. STREET ADDRESS <u>01X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kiser Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Thomas</u> Middle <u>Morgan</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Industry</u>	11. BIRTHPLACE (State or foreign country) <u>MOSCOW</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Morgan</u>	
14. MOTHER'S MAIDEN NAME <u>Liza Lee</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>KISER NURSING HOME, OAKLAND, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Trauma</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Neck</u> DUE TO (c) <u>Methicillin</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>THIRDS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>199.1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-16</u> , 19 <u>59</u> , to <u>2-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>59</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Feister Jr.</u>		ADDRESS (Street, city or town, state) <u>55 2nd St. Oakland, Md.</u>	
DATE SIGNED <u>2-25-59</u>		DATE SIGNED <u>2-25-59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES H. FEISTER JR. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/27/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Moscow, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE EICHHORN</u>		ADDRESS <u>LONACONING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Kraus</u>	



## 1913 CERTIFICATE OF DEATH

01916

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>Md</u> COUNTY <u>Garrett</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Friendsville Md</u>		LENGTH OF STAY (in this place)		TOWN <u>Friendsville Md</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>GRACE R PLASKETT</u>				<u>Feb 5 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb 21 - 1880</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeper</u>		11. BIRTHPLACE (State or foreign country) <u>Addison Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Rudolph Faucett</u>				14. MOTHER'S MAIDEN NAME <u>Eliza J. Walters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S ADDRESS <u>John R. Plaskett, Friendsville Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardio-Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Aging</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. of work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1958</u> to <u>Feb 1959</u> , that I last saw the deceased alive on <u>Feb 4, 1959</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Pedro Rivera</u> M.D. <u>Friendsville, Md</u>				DATE SIGNED <u>3/5/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-8-59</u>		NAME OF CEMETERY OR CREMATORY <u>Addison Cemetery</u>		LOCATION (City, town, or county) <u>Addison</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Rodakowski</u>		ADDRESS <u>Marbleburg Pa</u>	
DATE <u>FEB 9 1959</u>							

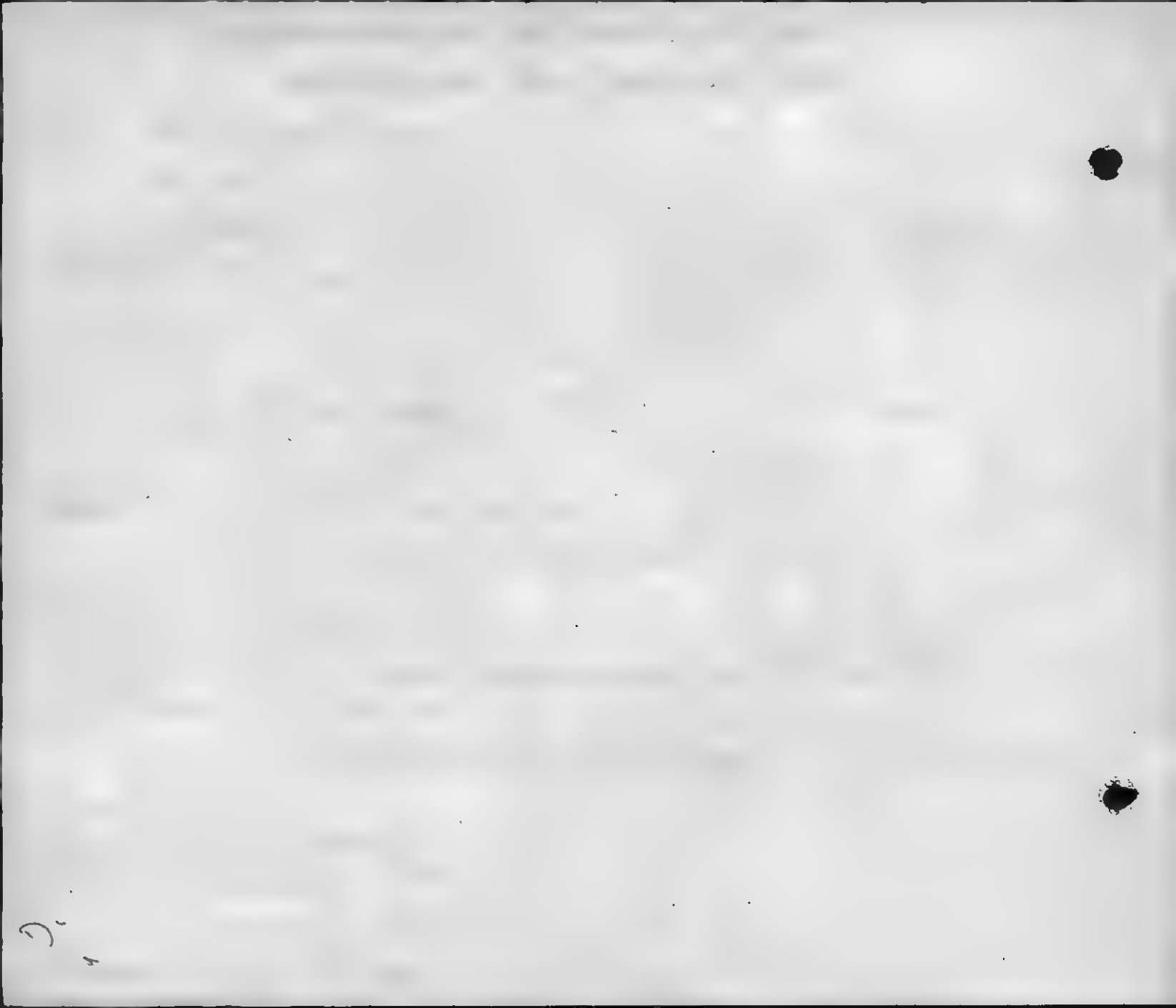
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01917

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>7 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett Co. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Galen</b> Last <b>Sweitzer</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-11-37</b>
9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Forests &amp; Parks</b>	
11. BIRTHPLACE (State or foreign country) <b>Swanton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Sweitzer</b>		14. MOTHER'S MAIDEN NAME <b>Amy Charlotte Harvey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-36-6369</b>	
17. INFORMANT <b>Wife (Alberta Sweitzer)</b>		Address <b>Swanton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> 1967 DUE TO <b>Especially both lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diffuse sarcomatous + Metastatic</b> DUE TO <b>Osteogenic sarcoma - Left Femur</b> (c) <b>Known</b> 21 months			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 year</b> <b>known</b> <b>21 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pathology Reports of left leg amputation + segmental bony resection</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>Feb 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 17</b> , 19 <b>59</b> , and that death occurred at <b>8:25 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, State) <b>77 Oak St. Oakland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.,</b>		DATE SIGNED <b>19 Feb 59</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>George Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Swanton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 24 59</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. M. M. M.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Wm. J. Smith

1000 1500 1600

1000 1500 1600

1000 1500 1600

1945  
CERTIFICATE OF DEATH

01918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>	
c. LENGTH OF STAY IN 1b <u>12 days</u>		d. STREET ADDRESS <u>714 and Alder Streets</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Idella</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Amos Jefferys</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Glover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. P. R. Metheny, Terra Alta, W. Va.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Pneumonia - left lung</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 month</u> <u>unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 16, 1959</u> to <u>Feb 28, 1959</u> , that I last saw the deceased alive on <u>Feb 27, 1959</u> , and that death occurred at <u>1:00 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Leighton, M.D.</u>		ADDRESS (Street, city or town, state) <u>77 Oak St. Oakland, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert H. Leighton, M.D.</u>		DATE SIGNED <u>28/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal &amp; Burial</u>		22b. DATE THEREOF <u>3/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Terra Alta Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Terra Alta, West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. R. Watson</u>		ADDRESS <u>Terra Alta, West Virginia.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	
DATE <u>MAR 2 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

